Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DANIEL A BOUDREAU, D.O
14493A SOUTH PADRE ISLAND DR #349
CORPUS CHRISTI TX 78418

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1860-02 formerly M4-12-1860-01

MFDR Date Received
January 30th, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor has not provided a position statement with their Medical Fee Dispute submission.

Amount in Dispute: $1075.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that the bill reference in this MDR has been sent for reprocessing to our bill review vendor. If anything additional will be recommended post-review, it will be issued promptly."

Response Submitted by: Gallagher Bassett, 6750 W Loop South #300, Bellaire, TX 77401

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28th, 2011	99456-W5 and 96116	$1075	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 29th, 2011
   - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Were the services in dispute billed appropriately per 28 Texas Administrative Code §134.204?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $950.00 for CPT Code 99456-W5 for both Maximum Medical Improvement (MMI) and Impairment Ratings(IR) for the lumbar spine and right knee. The requestor also billed CPT code 96116 a neurobehavioral status exam. Review of the DWC-032 indicates that the exam was to determine the Maximum Medical Improvement(MMI) and Impairment Rating. The documentation submitted by the provider supports that MMI was assigned and that two body areas were rated. The lumbar spine and right lower extremity are the areas rated. Per Texas Administrative Code §134.204(j)(4)(C)(iii) states "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP' Reimbursement shall be 100 percent of the total MAR." Per the submitted documentation the examining doctor performed the MMI examination and IR testing of two musculoskeletal body areas, but did not bill using the required modifier "WP".
2. Review of the submitted documentation supports that the Division ordered the examination, yet any reimbursement was contingent upon the use of modifiers as explained in Texas Administrative Code §134.204. The medical bills submitted by the requestor for review does not reflect that the appropriate modifiers were applied to CPT Code 99456-W5, therefore, reimbursement is not recommended.
3. The requestor was previously reimbursed $125.00 for CPT Code 96116 on check number 0065373632 dated April 29th 2011. Additional reimbursement for CPT Code 96116 is not recommended. The Division finds that CPT Code 99456-W5 was not appropriately billed. Therefore no additional reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/23/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.